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Supreme Court, U.S.
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No. —

IN THE

Supreme Court of the United States

PAUL JEFFREY DAVIS,

Petitioner,

v.

STATE OF CALIFORNIA,
BOARD OF CHIROPRACTIC EXAMINERS,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL THIRD APPELLATE DISTRICT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1.

Whether Certiorari Should Be Granted to Determine If California's Standard for Depriving State Licensed Doctors of Chiropractic of Their Right to Practice Their Profession Is "Void for Vagueness."

2.

Whether Certiorari Should Be Granted Because California Has Applied its Statutory Standard for Discipline of Chiropractic Licensees in an Irrational Manner in Violation of Due Process

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Petitioner, PAUL JEFFREY DAVIS, respectfully prays that a writ of certiorari issue to review the decision of the Third District California Court of Appeal, affirming the decision of the Sacramento Superior Court denying him relief from the discipline imposed on his license by the State Board of Chiropractic Examiners.

OPINION BELOW

The Opinion of the Court of Appeal, which was filed on April 12, 2010, as well as the order of the California Supreme Court denying Dr. Davis' petition for discretionary review, are reproduced at Appendix, pp. 1-25.

JURISDICTION

Jurisdiction of the Court is invoked pursuant to 28 U.S.C. Section 1257, subdivision (a). The order of the State Supreme Court denying discretionary review was entered on July 14, 2010. Under Rule 13.1 of the Rules of this Court, this Petition is timely filed.

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

The Fourteenth Amendment to the United States Constitution provides that no state shall deprive "any person of life, liberty or property without due process of law." Appendix, p. 26.

Those statutes and provisions are: (1) California Administrative Code, Title 16, Section 317, Subsections (a) - (d), Appendix, p. 26; (2) California Administrative Code, Title 16, Section 318, Subsection (b), Appendix, p. 27; and (3) California Labor Code, Section 4600. Appendix, pp. 27-28.

HOW THE FEDERAL QUESTIONS WERE RAISED AND DECIDED BELOW

The federal questions presented on this Petition were raised in Petitioner's defense of the accusations against him promulgated by the California Board of Chiropractic Examiners ("Board"), in his Petition for an Administrative Writ in the Superior Court and on appeal from denial of that relief in the California Court of Appeal and Supreme Court.

The Court of Appeal addressed the issues extensively.

The opinion of the Court of Appeal sets out the evidentiary framework of the case, but overlooks some factual aspects of the case, which are significant for an understanding of the arguments set forth here by Petitioner.

For example, the Opinion does not mention a fact clearly shown by the record. Although the audit (voluntarily conducted by Dr. Davis himself) revealed 114 errors and some were in favor of the insurers, of the errors in Dr. Davis' favor, there were only 16 billed services that resulted in over billing to Highland Insurance Co. and two errors that resulted in over billing to Superior National Carrier and that the amount over billed was $147.23 (Highland) and $9.22 (Superior National).

When the Opinion treated this as a sufficiency of the evidence appeal disguised as an appeal on an issue of law, it concluded the record established gross negligence because Dr. Davis was not diligent enough to prevent these extremely minor errors. Appendix, p. 4 ["114 billing errors"], p. 15 [referring to "numerous erroneous bills to Highland and Superior"], p. 15 ["based on the 114 errors and Dr. Davis' own admission that he had nothing to do with the billing, there was ample evidence to support the finding of negligence, whether or not he had notice of the errors"].

The Opinion also states in this connection that the Board Disciplined Dr. Davis "for errors in his billing" but does not discuss whether the "Legal Conclusions" (Appellant's Appendix, Tab 4, p. 000036, ¶2.) of the Board where the Board stated that:

> "Cause exists for discipline of" Dr. Davis because of his "failure to ensure accurate billing and his failure to correct the erroneous billing within 30 days after discovery of the errors"

means, as Petitioner contends, that it was the combination of (relatively minor) billing errors **and** the failure to correct them within the 30 days that resulted in his discipline, or that the Board was concluding that there is no safe harbor in case a licensee makes billing errors but does correct them within 30 days of notification or discovery.

The Opinion would lead one to conclude that neither the Board nor the Attorney General acknowledged the possibility that prompt correction of billing errors may allow a licensee to escape discipline for unprofessional conduct in the proceedings before the Board, which is not accurate.

On the issue of excessive treatment, the Opinion seems to contradict itself in first saying that the lack

of records showing the patient reported pain equates to excessive treatment, and then saying that a patient cannot be treated whenever "he felt he needed" it. Appendix, pp. 10, 21.

The Opinion goes on to rely on Dr. Rake's testimony that what Dr. Davis (Petitioner) did wrong was not keep records of the patient's subjective report of pain. *Id.*, pp. 18, 22, 23. Specifically, at page 22 of the Appendix, the Opinion recites that Dr. Rake faulted Dr. Davis for failing to document "the patient's complaints." This appears to be inconsistent with the primary reason the Opinion finds that Dr. Davis was unprofessional in treating the patient, because the trial court found that the patient's "subjective belief regarding the benefits of treatment" do not override Dr. Rake's opinion of community standards. Appendix, p. 18.

The statement of relevant facts in the Opinion appears to be incomplete and to give an inaccurate picture of the basis of Dr. Rake's opinion that Dr. Davis was guilty of excessive treatment. The Opinion states that Dr. Rake's expert opinion of community standards overrides the patient's subjective belief he needed treatment for his pain. Opinion, p. 18 [quoting and crediting the trial court's purported "factual finding."] Petitioner submits that a conclusion about what "overrides" what is not a factual conclusion but a legal one.

If the problem with Dr. Davis's records was that they did not record the patient's subjective complaints, or the patient's post treatment report that the treatments alleviated his pain, then what community standards did Dr. Rake describe that "overrides" that? Dr. Rake testified that "community standards" require "if the patient does not improve" then the "course of treatment should be modified." Appendix, p. 18.

However, the Opinion overlooks the fact that: (a) the records that Dr. Rake faulted Dr. Davis for not providing were records that merely recorded the patient's subjective symptoms going in, and his own subjective report of the effect of treatment going out; and (b) records of that kind were not required in 2002 when this patient was last treated. Specifically, the Opinion quotes Dr. Rake as referring to the absence of "pain scales" and "outcome assessment questionnaires." (*Id.*, p. 22) It further quotes him as saying that "the key nowadays for ongoing care would be the assessment questionnaire, which has more validity than the doctor's physical exam." *Id.*, pp. 24-25. The Opinion does not note, however, that "nowadays" [when Dr. Rake was testifying] was 2006, not 2002, when Dr. Davis last treated the patient.

In addition, this testimony is just another way of saying the doctor should ask the patient about his pain, and rely on that rather than his own professional judgment following an exam. Still, Dr. Davis was faulted by the Board for letting the patient decide when he needs treatment.

Relying on subjective questionnaires of the patient is no different than allowing the patient to report that his back hurts again, and treating him for the recurring pain.

More importantly, perhaps, the subjective assessment tools specifically referred to by Dr. Rake as those preferred "nowadays" were the American College of Occupational and Environment Medicine's Occupational Medicine Guidelines, which only became presumptively correct on March 22, 2004, well after this patient was last treated. See *Smith v. Churn Creek Construction*, 69 Cal.Comp.Cases 1012,1014

(2004); *Sierra Pacific v. WCAB (Chatham)*, 140 Cal.App.4th 1498, 1512 (2006).[1]

Finally, the Opinion fails to note that Dr. Rake actually corrected his testimony that is referred to in the Opinion, to the extent he has stated that in "only 2 or 3" of the 24 or 25 re-exams were "the subjective finds for the patient's complaints . . . actually documented."

Later in his testimony, Dr. Rake admitted that "in light of the new documentation" brought to his attention in the file, it was inaccurate that there was no documentation of the pain reported by the patient or the treatment received. (See Transcript of Admin. Proc., 8/16/06, pp. 67-71). This documentation was a series of "flow sheets" in use in 2002 and before, documenting the patient's complaints and treatment.

Finally, although the Opinion cites to the uncorrected testimony in support of the "excessive treatment" ruling (*Id.*, p. 22), the Board's expert was referring to improper billing in that part of his testimony because the re-exams were not documented. (Transcript of Admin. Proc., 8/16/06, p. 68.)

Proceedings in the Superior Court were initiated by the filing of Dr. Davis' Petition for Writ of Administrative Mandamus, pursuant to California Code of Civil Procedure, Section 1094.5, on June 8, 2007.

The Petition alleged that on or about September 15, 2004, the Board filed an accusation against Dr.

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[1] Petitioner notes, however that even these standards and guidelines apply only to patients, unlike J.T., who are not permanent and stationary, but have suffered pain for 90 days or less.

Davis seeking discipline.[2] The Accusation was amended twice. The Second Amended Accusation was the operative administrative pleading. On August 14-18, 2006, a hearing was held in Santa Ana, California before an Administrative Law Judge (ALJ), who rendered a Proposed Decision on March 5, 2007.

The proposed decision found cause for imposing discipline, found that there was no intent to defraud, moral turpitude or any dishonesty or corruption, or any knowing presentation of false insurance claims. It also found substantial mitigating evidence. The discipline recommended by the ALJ was: (1) Revocation of Dr. Davis's license; and (2) Revocation to be stayed and Dr. Davis placed on probation for three years, on numerous conditions.[3]

The Proposed Decision was reviewed by the Board and on April 12, 2007, the Board adopted the Proposed Decision with minor changes not affecting either the discipline or the findings of mitigation.

Dr. Davis filed a timely motion for reconsideration of the Decision of the Board, which was denied on May 15, 2007.

In his Superior Court petition, Dr. Davis alleged that he was entitled to relief because: (1) the Board failed to follow the procedures set forth in Government Code Section 11517(c)(2)(E); (2) the Board violated Dr. Davis' right to due process and to a fair hearing and decision; (3) the discipline imposed was an abuse of discretion; (4) the factual findings are not supported by

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[2] The original Accusation was not filed with the Superior Court. Please see Petition, AA, Tab. 2, ¶ 3, p. 3.

[3] Although this punishment may appear to be insignificant, the actual consequence of the discipline imposed was to destroy Dr. Davis' practice. The decision against him has been published in the industry journals, and no insurer will currently approve of any patient being treated.

the weight of the evidence; (5) the attorneys fees award was not reasonable in light of the fact that Dr. Davis defeated the more serious charges in the Second Amended Accusation and the Board changed attorneys, thus increasing fees through no fault of Dr. Davis; (6) the conclusions of law (in the Decision of the Board) are not supported by the Findings of Fact; and (7) the Decision of the Board was an abuse of discretion and exceeded the Board's jurisdiction.

On December 14, 2007, the matter came on for a hearing on the Petition, and the Superior Court entered a tentative ruling, denying the Petition in its entirety.

A formal Ruling on Submitted Matter was executed by the Superior Court on February 25, 2008. On May 21, 2008, the Superior Court filed a Judgment Denying Petition for Writ of Mandate, referencing the court's Ruling on Submitted Matter.

Dr. Davis argued that the unprofessional conduct he was accused of was based on a regulation that is void for vagueness [Title 16 California Administrative Code, Section 317(d)], (and as applied to him failed to afford him adequate notice under the due process clause of the Fourteenth Amendment. He further argued that he was not negligent in his billing in violation of the other regulation relied upon, and that in any event, the plain language of the statute established that his conduct did not amount to unprofessional conduct, because all billing errors were corrected within 30 days of his discovery of them.

The Court of Appeal ruled that Section 317, subsection (d) was not void for vagueness, despite the lack of any standards, and that Section 318, subsection (b) not only did not provide a safe harbor for licensees whose billers make billing errors, the errors themselves are "gross negligence" constituting grounds for discipline.

SUMMARY OF ARGUMENT

This Court should grant certiorari to address the practice of the State of California, through its Board and the Courts of that state, of disciplining chiropractors based on standardless regulations, and by ignoring the clear language of a regulation, both of which violate due process and deprive the licensees of property without due process.

ARGUMENT

1.

Certiorari Should Be Granted to Determine If California's Standard for Depriving State Licensed Doctors of Chiropractic of Their Right to Practice Their Profession Is "Void for Vagueness"

Claims that state laws are unconstitutionally void for vagueness are reviewed *de novo*. *Fleisher v. City of Signal Hill*, 829 F.2d 1491, 1496 (9th Cir.1987).

Petitioner has argued that Section 317, subsection (d) of Title 16 of the California Administrative Code is unduly vague, in violation of the right of due process as guaranteed by the United States Constitution.

Section 317(d) provides:

> "Unprofessional conduct includes, but is not limited to, the following: (d) The administration of treatment or the use of diagnostic procedures which are clearly excessive as determined by the customary

practice and standards of the local community of licensees."[4]

Petitioner's discipline was based in large part on a finding by the ALJ, adopted by the Board, that he violated Section 317(d). Specifically, the finding below said:

"Cause exists for discipline . . . because Respondent's conduct as set forth in Findings 12, 13, 14 and 15, violated Business and Professions Code Section 725 and California Code of Regulations, title 16, section 317."

In omitted footnotes, the decision references the "clearly excessive" and "community of licenses" language from Section 725, and the "clearly excessive" and "local community of licensees" language from Section 317, subdivision (d).

The Proposed Decision states:

"This is where respondent's treatment became excessive. J.T. began dictating when he needed treatment and he was treated on this 'as needed' basis as frequently as J.T. believed he should be treated."[5]

The ruling also stated: "These treatments made J.T. feel better, so he continued treatments." "Consequently, respondent was repeatedly negligent and acted in a grossly negligent manner in his treatment of J.T. by allowing J.T. to become

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[4] California Business and Professions Code Section 725 states that "repeated acts" of clearly excessive treatment as determined by the "customary practice and standards of local community of licensees" constitutes "unprofessional conduct" for which a licensee may be disciplined.

[5] The ruling also stated that "if the patient is not improving, then the course of treatment should be modified or discontinued. If the patient is not improving the treatments must be changed, or the patient should be referred to another provider." *Id.*

dependent, by providing treatments that were not medically necessary and by fostering chronicity."

In view of the fact that the Board's discipline of Petitioner was based in large part on the findings that: (a) the treatment of J.T. was "clearly excessive" (b) the term "customary practice and standards of the local community of licensees." was not defined at all by the ALJ, the Board or the Superior Court; and (c) since Petitioner's expert, a former member of the Board, testified that Petitioner's treatment of the patient J.T. was "not excessive" in his expert opinion, the statutory standard "clearly excessive" is unconstitutionally vague.

Rules and statutes must be sufficiently clear as to give a fair warning of the conduct prohibited. This prohibition against vagueness has been held to extend to administrative regulations affecting conditions of governmental employment. Please see *Bence v. Breier*, 501 F.2d 1185, 1188 (7th Cir.1974), cert. den., 419 U.S. 1121, 95 S.Ct. 804, 42 L.Ed.2d 821 (1975) ["the prohibition against vagueness extends to administrative regulations affecting conditions of governmental employment as well as to penal statutes...."]; *United States v. Mazurie*, 419 U.S. 544, 550, 95 S.Ct. 710, 714, 42 L.Ed.2d 706 (1975).

> "In examining statutes challenged on vagueness grounds, courts have looked not merely at the hypothetical cases to which the statute has uncertain applicability, but also at the act allegedly committed by the charged defendant." *United States v. National Dairy Corp.*, 372 U.S. 29, 32-33, 83 S.Ct. 594, 597-598, 9 L.Ed.2d 561 (1963).

In this case, the "act" allegedly committed by Dr. Davis was to treat a patient, who had been approved for treatment, to relieve that patient of recurring pain he was suffering from industrial accidents. There was

no charge of fraudulent billing, or of malingering by the patient. There was no suggestion that the patient was not actually in pain, or that the pain was not from the accidents.

The patient had been treated and improved as much as he was going to improve, but he returned to Dr. Davis for treatment when his pain returned, and Dr. Davis relieved his pain. The ruling below was not that Dr. Davis treated him *too many times* in the abstract, but only that he treated him too many times based only on the patient's complaints of pain. This was found to be "clearly excessive."[6]

If a disciplinary standard is so vague that no reasonable consensus may be formed as to its proper meaning, its application is constitutionally suspect.

The policies underlying the proscription against vagueness are well established. *Grayned v. City of Rockford,* 408 U.S. 104, 108-109, 92 S.Ct. 2294, 2298-2299, 33 L.Ed.2d 222 (1972), fns. omitted; *Hoffman Estates v. Flipside, Hoffman Estates, Inc.,* 455 U.S. 489, 498, 102 S.Ct. 1186, 1193, 71 L.Ed.2d 362, rehg. den., 456 U.S. 950, 102 S.Ct. 2023, 72 L.Ed.2d 476 (1982).

In short, "[t]he root of the vagueness doctrine is a rough idea of fairness." *Colten v. Kentucky*, 407 U.S. 104, 110, 92 S.Ct. 1953, 1957, 32 L.Ed.2d 584 (1972).

This Court applies the same verbal test to determine if a statute violates due process because it is vague.

> "[A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law." *Connally v. General Construction Co.*,

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[6] Appendix, p. 17.

269 U.S. 385, 391, 46 S.Ct. 126, 127, 70 L.Ed. 322 (1926).

Applying these rules to the language at issue in the present case, it is clear that the term "excessive treatment" is unconstitutionally vague.

Here, however, it cannot be said that treating a patient for pain, under a plan the ALJ and Board found to be properly diagnosed initially, "falls clearly within [the] bounds" of a regulation that prohibits "clearly excessive treatment."

This provision "is vague 'not in the sense that it requires a person to conform his conduct to an imprecise but comprehensible normative standard, but rather in the sense that no standard of conduct is specified at all.' [Citation.] Such a provision simply has *no* core." *Smith v. Goguen,* 415 U.S. 566, 578, 94 S.Ct. 1242, 1249, 39 L.Ed.2d 605 (1974), emphasis in original.

Relying on state law, the Court of Appeal found that even though the words "clearly excessive" or "excessive treatment" has no meaning considered by itself, the balance of the language of the regulation referring to "local community standards" saves the vague part from impermissible vagueness.

> "We do not assess the vagueness challenge to the statute and regulation in the abstract but in light of the facts of the case before us. (*Cranston v. City of Richmond* (1985) 40 Cal.3d 755, 764, 221 Cal.Rptr. 779, 710 P.2d 845.) Dr. Davis treated J.T. over 100 times for his sprained ankle and over 160 times for his sore back. He contends there is no standard number of treatments or standardized protocol against which his care of J.T. can be measured. But 'where the language of a statute fails to provide an objective standard by which conduct can be judged, the required

> specificity may nonetheless be provided by the common knowledge and understanding of members of the particular vocation or profession to which the statute applies.' (*Id.* at p. 765, 221 Cal.Rptr. 779, 710 P.2d 845.)
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> "***9** Indeed, Board Regulation section 317, subdivision (d) codifies that very principle. It states that unprofessional conduct includes treatments 'which are clearly excessive as determined by the customary practice and standards of the local community of licensees.' Dr. Davis insists the definition is unconstitutionally vague because the Board's expert testified the number of treatments he provided J.T. was excessive and his expert testified they were not. He concludes there is no standard when even the experts disagree. Not so. If expert witnesses had to agree in order to establish customary practice or standards, there would be few, if any, standards of practice since it is easy to retain an expert witness to express an errant view." Appendix, pp. 17-18.

In this case, of course, Dr. Davis did not retain an expert to express an errant view. Rather, he retained the immediate past vice chair of the respondent Board, and his opinion was not pulled from thin air, but based on the statutory law of the State of California. Specifically, he testified that under the provision of the California Labor Code addressing worker's compensation treatments, treating a patient merely to relieve pain is specifically authorized. Indeed, California Labor Code 4600 reads in relevant part: "chiropractic, . . . treatment, . . . that is reasonably required to cure or relieve from the effects of the injury shall be provided by the employer." In other words, under California law, treating pain is not only

permissible but explicitly required for a patient who, like J.T. in this case, is injured in a work related incident. Moreover, case law supports the view that treatments which alleviate a patient's pain is medically appropriate treatment.

In fact, J.T. testified that the treatments Dr. Davis provided did relieve his pain and help him improve. RT, 8/15/06, 96:17-25, 105:14-16.

The Board offered no rebuttal evidence to this crucial fact. All the evidence showed that Appellant's care relieved J.T. of his pain.[7]

In *Braewood Convalescent Hospital v. W.C.A.B.*, 34 Cal.3d 159, 169 (1983), the State Court explicitly ruled that:

> "The present treatment aimed at affording applicant relief from the effect of an industrial injury represents a compensable expense under Section 4600."[8]

Petitioner submits that the mere fact that the expert called by the Board testified that in his opinion the number of treatments was "excessive" cannot change the fact that: (a) the record contains no evidence of any local community standards; (b) California law explicitly approves of the types of treatments involved here -- treatment for pain; and (c) there is a constitutional difference between an actual standard by which a vague term like "clearly excessive treatment" can be measured, and a mere opinion of a single doctor.

In the present case, the Board and the Court below also failed to apply the statutory language requiring evidence of the standards of a "local" community of

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[7] RT, 96:17-25 (August 15, 2006); 105:14-16 (October 26, 2006).

[8] The statute has been amended but in this regard it continues to sanction pain relief.

professionals, but insisted that the word "local" in the statute means "the entire state of California." Consequently, Petitioner argued that the phrase "local community" was also impermissibly vague, but the court below simply rejected this contention without any reasoning.

> "Finally, Dr. Davis complains the regulation is vague because it does not define a 'local community,' and it was unconstitutionally applied because the experts relied on chiropractic standards throughout the state. He made no attempt to prove the standard for excessive treatment varied within the state. We believe that people of common intelligence can discern the meaning of local community, and in the absence of evidence that the standard applicable to this case varied throughout California, we conclude the regulation survives constitutional scrutiny."

The court's "belief" on this point is not constitutionally anchored, or it is persuasive. Unvarnished, the record in this case consisted of two chiropractors disagreeing about whether or not the treatment in this case was excessive -- not about what the local standards were by which the otherwise empty "clearly excessive treatment" was measured.

Moreover, the Opinion below betrays the fact that it was neither the number of treatments, nor the reason for the treatments, that caused the court to find Dr. Davis excessively treated J.T., but the fact that he, himself, was allowed to decide when he needed treatment.

> " 'After the initial course of therapy, J.T. began scheduling appointments whenever he felt he needed them. J.T. would make his appointments, arrive at respondent's facility, be treated by one of respondent's

employees/chiropractic assistants with massage, ultrasound, electrical stimulation, RICE, etc. These therapies made J.T. feel better, so he continued the treatments even though there was no medical necessity for the nature and number of the continued "treatments." Consequently, respondent was repeatedly negligent and acted in a grossly negligent manner in his treatment of J.T. by allowing J.T. to become dependent, by providing treatments that were not medically necessary and by fostering chronicity.'

"**11 * * * As a matter of law, an injured worker may be entitled to future medical treatment to stabilize and maintain a permanent injury, but as a matter of fact, the patient may not be entitled to unlimited treatment to feel better. Because in this case the administrative tribunal as fact finder found that Dr. Davis negligently fostered J.T.'s dependency on treatments and negligently authorized his staff to provide feel-good treatments on demand, we reject Dr. Davis's argument that he provided 'excessive treatment' as a matter of law once J.T.'s condition became permanent and the treatments targeted pain relief.

"* * * Dr. Rake explained at some length how Dr. Davis failed to document or record J.T.'s subjective complaints. He testified: 'Again, I did see rexams [*sic*]. Again, I have no problem with rexams [*sic*]. The problem I have is <u>there was no information regarding the subjective complaints</u> on the rexams [*sic*], in the SOAP notes or on the flow sheets that I could find to correlate the rexams [*sic*]. For example, out of-I think there were 24 or 25

> total examinations for these two work comp cases-conditions. Out of the 24 or 25 rexams [*sic*], I only found two or three of the exams where the subjective finds for the patient's complaints were actually documented. So I had about 22 rexams [*sic*] being performed for what? What was the purpose? What were the patient's complaints? How were they getting better? How were they getting worse? Were they having any radiating pain? Was their work aggravating their conditions? Was their care beneficial at that point? Was there a pain scale performed? Were outcome assessment questionnaires utilized to determine scientific basis for ongoing care? The key nowadays for ongoing care would be the assessment questionnaire, which has more validity than the doctor's physical exam finding to support ongoing care.'
>
> "Thus, Dr. Rake concluded the treatment was excessive, not because a chiropractor can never provide treatment for pain relief, but because Dr. Davis failed to record J.T.'s subjective complaints. The failure to document the need for pain relief leaves open the question whether Dr. Davis ever inquired or not. We reject his contention, however, that the finding of excessive treatment was based on the wholesale legal proposition that chiropractors cannot treat injured workers to ameliorate their pain." Appendix, pp. 21-23.

Ironically, the Opinion below is a piece of circular reasoning. It progresses as follows: (1) Dr. Davis was guilty of excessive treatments because he only treated the patient for pain; (2) Treating for pain is not itself excessive; (3) Here there was no record of the need for

the treatment; (4) The records needed would have recorded the patient complaining about pain.

Apart from the fact that there is no question that the standard for records used by the Board's expert were 2006 standards adopted at least two years after Dr. Davis stopped treating J.T., the Opinion is not accurate in that the Board's expert later corrected the quoted testimony and admitted he did find records of the patient's complaints of pain in his review of Dr. Davis' file. This documentation was a series of "flow sheets" in use in 2002 and before, documenting the patient's complaints and treatment.

In addition, although the Opinion cites to the uncorrected testimony in support of the "excessive treatment" issue (*Id.*, p. 22), the Board's expert was referring to improper billing in that part of his testimony not to the issue of excessive treatment. (Please see Transcript of Admin. Proc., 8/16/06, p. 68.)

Finally, unlike other vague terms that can be determined by reference to common practice, the term "excessive treatment" has no "inherent, objective content from which ascertainable standards defining the proscribed conduct can be fashioned" by reference to the community of chiropractors. Compare *California School Employees Assn. v. Foothill Community*, 52 Cal.App.3d 150, 156, 124 Cal.Rptr. 830 (1975); *Jabola v. Pasadena Redevelopment Agency*, 125 Cal.App.3d 931, 935, 178 Cal.Rptr. 452 (1981). The term is not rendered any more specific by addition of the ambiguous phrase, "as determined by the practices and standards of the local community of licensees."

There *is no* recognized standard of professional conduct for chiropractors, and the term "local community" has not been defined by statute or case law. The phrase "local community" "sets forth no basis by which [a licensee] may by placed on notice of what 'conduct' the [Board] may treat as 'excessive

treatment.' " Therefore, section 317, subsection (d) is not analogous to the rule relied on by the Court of Appeal, which permitted discipline for " 'conduct unbecoming an officer" *Perea v. Fales,* 39 Cal.App.3d 939, 942, 114 Cal.Rptr. 808 (1974). The limitation of the standard in that case to conduct unbecoming *a police officer* provided, in light of the "common knowledge of members of the particular vocation," "fair warning of which conduct is prohibited and which is permitted." *Id.,* at p. 942.

Here, however, in light of the record, which contains only the divergent opinions of two expert witnesses, one of whom concluded that the treatment of J.T. *was* excessive, and the other of whom concluded it was not, it cannot be said that there is any "common knowledge" of members of the chiropractic profession which establishes whether or not treating pain when it manifests itself in an existing patient constitutes "excessive treatment" merely because it does not "cure" the cause of the pain.

This Court has previously noted that there are inherent due process problems with what happened in this case. In *Smith v. Goguen, supra,* 415 U.S. at p. 580, 94 S.Ct. at 1250 this Court noted "the problems presented by an appellate court's limiting construction in the very case in which a defendant has been tried under a previously unnarrowed statute." At the very least, Section 317, subsection (d) is a "previously unnarrowed statute" and the state court has approved of the destruction of one of the very best Doctor's of Chiropractic in the state by means of a retroactive, or *ex post facto* construction of it to cover his conduct in this case.

The plain language of section 317(d) provides no ascertainable objective standard by which a licensee could determine whether his conduct would subject him to discipline. And this is particularly true here

where the doctor had appropriately determined the patient's conditions, treated them, and the patient could not be cured, but would continue to suffer pain periodically.

A licensee who is treating pain, as the findings of the Board clearly states Petitioner was doing by treating J.T. when he presented himself to the office with a complaint of pain, would have no way of knowing that the Board or some court would determine, after the fact, based on a disputed opinion of an expert, that this treatment was "clearly excessive" under this previously "unnarrowed" rule.

Dr. Martello, the Board's own former Vice-Chairman, testified that no published standard of care exists in California and neither the state nor the court below disagreed.[9] Furthermore, Dr. Martello testified that in his professional opinion, Davis' treatment of J.T. was not excessive.[10]

J.T. testified that after Davis declared him to be "permanent and stationary," J.T. scheduled most, if not all, of the "after-care" treatments in order to relieve pain flare-ups caused by his industrial injuries. RT, 100:2-22 (August 15, 2006). Under Section 4600, the California Workers' Compensation system allows J.T. to do just that.

Furthermore, the Board's decision ignored evidence that Petitioner treated J.T. on a decline-in-frequency basis for both injuries.[11] In other words, the number of treatments deliberately decreased over time. Petitioner's expert evidence provided at trial supported the inference that the treatment provided

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[9] Transcript of Proceedings; 28:3-25 (August 17, 2006).

[10] Transcript of Proceedings; 61:7-11; 61:24-62:3; 62:8-11 (August 17, 2006).

[11] RT, 96:17-25 (August 15, 2006).

by Appellant was not excessive under any standard.[12]

According to the Opinion below, that expert testimony established that the local community of licensees means all "California chiropractors," but that view conflicts with the use of the term "local community of licensees" in Section 317(d), since "local" never means "statewide" in this context, but means some smaller sub-group. Otherwise, the regulation would have said, "standards and practices of California licensees."

Petitioner should not be disciplined for treatments specifically allowed by California's Workers' Compensation system where the experts disagreed what the standard at issue means. Nor, as pointed out in the "facts" section of this Petition, was the conclusion that treating this patient for pain when he presented and complained of pain shown by the records of Appellant's practice to be "excessive" because those records did not contain any diagnostic support for the treatment. Rather, as the evidence shows (but the opinion does not acknowledge) the Board's expert conceded that his testimony relied on by the Court of Appeal was in error, and that the records further show that: (a) the specific tests he discussed were not required or prevalent when this patient was being treated for pain; but (b) they are essentially nothing but recordation of the patient complaining of his pain -- which Dr. Davis' flow sheets also recorded.

Under the due process standard established by this Court, the Regulation and the Business and Professions Code Section at issue here are unconstitutionally vague because it cannot reasonably be concluded that Appellant's expert, a past member of

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[12] RT, 61:7-11; 61:24-62:3; 62:8-11 (August 17, 2006).

the Board, is not a "man of common intelligence" and given his sincere and reasoned disagreement with the Board's expert regarding the meaning of "excessive treatment" as used in the regulation and statute, Petitioner "must necessarily guess at its meaning."

The term "clearly excessive" fails to advise chiropractors what will constitute prohibited treatment. The term "clearly" suggests, however, that some matters of opinion are so extreme as not to be subject to reasonable dispute. The result of this vagueness is that doctors can be accused of wrongs they could not have known they were committing. Petitioner could not have known that treating J.T. for pain would be "clearly excessive" in the eyes of the Board, and he cannot, consistent with due process, be punished for doing what he could not have reasonably foreseen was wrong. There is no means by which to measure "clearly excessive treatment" as the term is used in the challenged Regulation.

Because the standard set forth in Section 317(d), "clearly excessive treatment," is neither defined in the words of the regulation itself, nor ascertainable by any objective comparison to available standards, and because the phrase "local community of licensees" is not defined as "the community of all California licensees" or otherwise defined, and finally because the two experts expressed divergent opinions regarding whether or not treatment of J.T. for his pain (which all agree was effective to combat the pain) was or was not "clearly excessive treatment," the standard by which Petitioner's conduct was adjudged to be deficient was unconstitutionally vague under both federal and state due process standards.

Certiorari should be granted to decide whether or not the phrase "excessive treatment" as applied to Petitioner by the State in this case to treating a patient (who was already stabilized and whose

conditions were not improving with treatment) was so vague as to violate due process. Petitioner submits that the term is void for vagueness, and that the application of the term to Petitioner here violated the Fourteenth Amendment.

2.

Certiorari Should Be Granted Because California Has Applied its Statutory Standard for Discipline of Chiropractic Licensees in an Irrational Manner in Violation of Due Process

Dr. Davis was also disciplined in this case under Section 318, subsection (b) for billing errors.

It should be recalled that there were never any complaints by the insurers involved in this case that Dr. Davis over billed.[13]

> "Dr. Paul Davis, a 20-year veteran chiropractor in both neurology and orthopedics, for his treatment and billing of a single patient who suffered two industrial accidents at two places of employment with different insurers. Neither the patient nor the insurers accused Dr. Davis of unprofessional conduct. Dr. Davis had never had a workers' compensation patient with claims against two insurers simultaneously, and he had never had a complaint filed against him by a patient or an insurer." Appendix, p. 1.

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[13] Indeed, the Opinion below accurately sets forth the fact that Dr. Davis has never previously been disciplined, or accused of over billing. See Appendix, pp. 1, 8.

> "He became a diplomate in both chiropractic neurology and chiropractic orthopedics, a distinction earned by only a few chiropractors nationwide. Until the filing of the instant accusation, the record reflects that Dr. Davis enjoyed an unblemished 20-year chiropractic practice, devoting long hours to treating his patients. Neither patients nor insurers registered any complaints." Appendix, pp. 5-6.

As noted above, the errors, while numerous, were not all in Petitioner's favor, and resulted in no complaint by any insurer, and only involved a small amount of over billing - in the total amount of $156.45.

The actual dispute in the administrative law proceedings in this case, however, were not related to the alleged 114 billing errors, but in regards to the meaning of another statute that had never been interpreted by any court of record in California.

That statute, Section 318(b), reads:

> "Accountable Billings. Each licensed chiropractor is required to ensure accurate billing of his or her chiropractic services . . . whether or not billing for such services is accomplished by an individual or business entity other than the licensee. In the event an error occurs which results in an over billing, the licensee must promptly make reimbursement of the over billing . . .. Failure by the licensee, within 30 days after discovery or notification of an error which resulted in an over billing, to make full reimbursement constitutes unprofessional conduct."

The court below ruled that this subsection did not mean that the initial over billing was not "unprofessional conduct" but instead that the regulation defines two types of unprofessional conduct: (1) making billing errors in the first place; and (2)

failing to correct them within 30 days of "discovery or notification."

The regulation in question clearly says that a California chiropractor is required to "ensure accurate billing" but it also explicitly recognizes that not all chiropractors do their own billing.

And while the Opinion below found that *any* violation of a duty by a licensee constitutes "unprofessional conduct" exposing the doctor to discipline, it failed to explain the use of the phrase in the final sentence of Section 318(b).

As noted above, there is a context to the first sentence which requires the doctor to ensure accurate billing, and that context includes the fact that not all doctors do their own billing, and the fact that the regulation states that if the doctor becomes aware of errors, it is "unprofessional conduct" not to correct the errors within 30 days.

The Court's interpretation of Section 318(b) is irrational to the point of violating due process because its interpretation could never be guessed by any reasonable person practicing chiropractic. It conflicts even with the interpretation of the section by the Board's expert below. It also makes the term "unprofessional conduct" as used in the last sentence of the subsection surplusage, which violates established rules for statutory construction.

Petitioner submits that anyone reading Section 318(b) would conclude that it is only unprofessional for a California chiropractor to fail to correct billing errors resulting in over billing within 30 days of discovery or notification, but not to make such errors in the first place.

Under the authorities discussed in issue one, concerning whether a regulatory provision is "void for vagueness" if the language of the regulation fails to

put the person affected on reasonable notice of what conduct will subject them to the discipline, Section 318(b), as interpreted below also violates due process.

The first sentence of Section 318(b) sets out the requirement of accurate billings.

> "Each licensed chiropractor is required to ensure accurate billings of his or her chiropractic services whether * * * billing for such services is accomplished by an individual or business entity other than the licensee." Section 318(b), first sentence.

This sentence clearly imposes a duty on the chiropractor to "ensure accurate billing" but it does not state that this is a strict liability duty, which results in discipline even if the chiropractor is unaware of the fact that billing errors have been made. In fact, this sentence acknowledges that it is not uncommon for someone, or some entity, other than the licensee, to do billing for chiropractors, which the record shows to be the case here. Moreover, based on "undisputed evidence" in this case "[Administrative Law] Judge Hewitt concluded and the Superior Court agreed, that Davis was not aware of the 114 billing errors he made in JT's case . . .."[14]

The Court of Appeal held, however, that Petitioner's initial failure to bill accurately, even during the time he was not aware of the errors, constitutes "negligence" and "unprofessional conduct."

There are two problems with this analysis: (1) there is absolutely no legal authority for it in the published decisions of the California courts; and (2) it flies in the face of the plain language of the entire Regulation, which goes on to state:

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[14] Respondent's Brief filed by the Attorney General, "RB," p. 15. (Underlining supplied.)

> "In the event an error occurs, which results in an over billing, the licensee must promptly make reimbursement by his employer, agent or any other individual or business entity responsible for such error. Failure by the licensee, within 30 days of discovery or notification of an error which resulted in over billing, to make full reimbursement constitutes unprofessional conduct." Section 318(b), 2nd and 3rd sentence.

Reading the entire language of the Regulation it becomes clear that: (a) the term "promptly" must mean "promptly upon learning of the error" and (b) if errors are not corrected within 30 days, that is not "promptly."

The only "unprofessional conduct" defined in the Regulation appears to be the failure to make the corrections within 30 days of "discovery or notification."

But those terms -- "discovery and notification" also have not been defined in any published or authoritative rule or case.

Certainly, Respondent, which is the Board that has promulgated this Regulation, and its counsel, the state's lawyer, have not provided any legal authority that the last two sentences of Regulation 318(b) do not give the regulation the meaning Petitioner is urging -- that it is only unprofessional conduct for a chiropractor to fail to correct billing errors "promptly" after notification or discovery, and that "promptly" is within 30 days of notification or discovery.

Nevertheless, the Court of Appeal upheld the discipline of one of the profession's leading practitioners, who has never previously been complained against, and who has achieved a status earned by only a small percentage of the best chiropractors in this state, finding that he could be

disciplined for errors of which he was unaware, and that even if he corrected them promptly upon learning of them, he would *still* be subject to discipline for the initial unprofessional conduct of making the errors in the first place.

Even if the reasoning of the Court of Appeal were generally acceptable -- that under the umbrella statute, *any* violation of a duty is grounds for discipline -- this regulation published by the Board would create a problem for disciplining Petitioner based on his initial billing errors.

This is so because by juxtaposing in the first sentence reference to billing errors, with failing to correct them promptly upon notification or discovery in the last sentence, and then by limiting the application of the status of "unprofessional conduct" to the latter failure to promptly correct, the Board has created a trap for the unwary, and deprived chiropractors in Petitioner's position of adequate notice that merely making billing errors in the first place is grounds for revocation of their license.

Indeed, punishing a chiropractor for making billing errors, even where, as here, the Board implies that it is permissible to have others do the billing, and further states that failing to correct errors promptly upon discovery or notification is grounds for discipline, violates due process under the rule of *Raley v. Ohio*, 360 U.S. 423, 79 S.Ct. 1257, 3 L.Ed.2d 1344 (1959) and *Cox v. Louisiana*, 379 U.S. 559, 85 S.Ct. 476, 13 L.Ed.2d 487 (1965).

In these two cases, applying the notice aspect of the due process clause, this Court has found that convictions for violating apparently clear and

straightforward statutes[15] violated due process as applied.

This Court in *Raley* held:

> "A State may not issue commands to its citizens, under criminal sanctions, in language so vague and undefined as to afford no fair warning of what conduct might transgress them. *Lanzetta v. State of New Jersey*, 306 U.S. 451, 59 S.Ct. 618, 83 L.Ed. 888. Inexplicably contradictory commands in statutes ordaining criminal penalties have, in the same fashion, judicially been denied the force of criminal sanctions. *United States v. Cardiff*, 344 U.S. 174, 73 S.Ct. 189, 97 L.Ed. 200. Here there were more than commands simply vague or even contradictory. There was active misleading. Cf. *Johnson v. United States*, 318 U.S. 189, 197, 63 S.Ct. 549, 553, 87 L.Ed. 704. The State Supreme Court dismissed the statements of the Commission as legally erroneous, but the fact remains that at the inquiry they were the voice of the State most presently speaking to the appellants. We cannot hold that the Due process clause permits convictions to be obtained under such circumstances." *Raley v. Ohio*, *supra*, 360 U.S. at 438-439; 79 S.Ct. at 1266-1237.

Although the "voice of the state" was not crystal clear in *Raley*, this Court soon clarified that it is not necessary for the state to be explicit in order for the

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[15] Some defendants in that case were convicted of violating Ohio General Code § 12137 which provided that "a failure * * * to answer as a witness, when lawfully required" may be punished "as for a contempt." The other was convicted under Ohio General Code, § 12845, which punished those, summoned before a Committee of the State Legislature, who refuse "to answer a question pertinent to the matter under inquiry." *Raley v. Ohio*, *supra*, 360 U.S. at 425, 79 S.Ct. at 1259.

rule to apply. Thus, it is stated in *Cox v. Louisiana*, *supra*, 379 U.S. at 571, 85 S.Ct. at 484:

> "In *Raley v. Ohio*, 360 U.S. 423, 79 S.Ct. 1257, 3 L.Ed.2d 1344, this Court held that the Due Process Clause prevented conviction of persons for refusing to answer questions of a state investigating commission when they relied upon assurances of the commission, either express or implied, that they had a privilege under state law to refuse to answer, though in fact this privilege was not available to them. The situation presented here is analogous to that in Raley, which we deem to be controlling. As in Raley, under all the circumstances of this case, after the public officials acted as they did, to sustain appellant's later conviction for demonstrating where they told him he could 'would be to sanction an indefensible sort of entrapment by the State-convicting a citizen for exercising a privilege which the State had clearly told him was available to him.' *Id.*, at 426, 79 S.Ct., at 1260. The Due Process Clause does not permit convictions to be obtained under such circumstances." (Underlining supplied.)

In this case, the situation is analogous to the *Raley* and *Cox* cases.

At least by strong implication, the Board has informed licensees that if they promptly correct billing errors, i.e., within 30 days of notification or discovery, then they are not subject to discipline for "unprofessional conduct." The clear implication of the regulation is that the unknowing erroneous billing by an agent or employee of the doctor is not itself unprofessional *if* the errors are promptly corrected.

No licensee "should be held accountable for a violation of a statute whose commands are uncertain,

or subjected to [discipline] not clearly prescribed." *United States v. Santos*, 553 U.S. 507, 128 S.Ct. 2020, 2025, 170 L.Ed.2d 912 (2008).[16]

As a practical matter, the interpretation adopted by the Court of Appeal would discourage practitioners from correcting billing errors for fear that the correction would wake the sleeping giant and increase the chance that they would be disciplined for the corrected errors. In this case, for example, the record is clear that the insurer did not complain about the errors, and Petitioner corrected them once he conducted an audit and "discovered" the errors.[17]

Moreover, due process principles are implicated when the state strips a person of the right to practice his profession, even conditionally, by Board discipline, for those practitioners who promptly correct their errors. The interpretation adopted below deprived practitioner of notice that, despite the language of the regulation, they will not be able to avoid punishment or loss of their right to practice their profession by promptly correcting errors of which they were previously unaware.

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[16] In *Santos*, this Court interpreted an ambiguous term in a penal statute, but similar notice and due process reasoning applies here to the language of Section 318(d) which clearly leads any reasonable person to believe that merely making unintentional billing errors is not "unprofessional conduct" at a time when the licensee neither discovers nor is notified of them.

[17] There was a controversy below about whether he acted quickly enough because he conducted that audit after an attorney in a case in which Dr. Davis was not a party suggested that he had made billing errors in J.T.'s case, but he had reason to doubt that attorney's motive for making that accusation. Should this Court grant certiorari, and rule that the state has violated due process vis. the interpretation and application of Sections 317(d) and/or 318(b), it would be appropriate to remand this matter to the Court of Appeal to decide whether or not Petitioner did act promptly enough under the "discovery or notification" provision of Section 318(b).

The result in this case on this issue is all the more surprising because at the hearing below, the Board's own expert testified that the way he read Section 318(b) was that *if* billing errors are promptly corrected, there is in fact no discipline for the errors. (Admin. Rec., 8/16/06, p. 111.)

Ironically, the same Opinion (below) that rested its rulings largely on the testimony of Dr. Rake (the Board's expert) also ignored the fact that he believed that Reg. 318(b) did contain a safe harbor.[18]

Because the plain language of the Regulation appears to create a mechanism by which a practitioner like Petitioner, who did not know he made billing errors, can avoid a finding of professional misconduct if he corrects those errors promptly, and because the experts below agreed that the Regulation has that meaning, and because it is apparent that Petitioner and the majority of the practitioners in California have understood Regulation 318(b) to constitute a safe harbor, the interpretation of it by the Court of Appeal violates due process.

Conclusion

For all these reasons, this Court is urged to grant the writ and reverse the judgment of the state Court of Appeal affirming Petitioner's conviction.

WHEREFORE, Petitioner prays that this Honorable Court grant his Petition and issue its Writ of Certiorari.

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[18] Petitioner's expert did not disagree. In fact, the Superior Court did not even rule that there is no safe harbor, but, instead upheld discipline based on its finding that the evidence was sufficient to find that more than 30 days passed between "discovery or notification" and correction of the billing.

Respectfully submitted this 12th day of October, 2010.

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APPENDIX

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Appendix 1

2010 WL 1434322 (Cal.App. 3 Dist), 75 Cal. Comp. Cases 465

California Rules of Court, rule 8.1115, restricts citation of unpublished opinions in California courts.

Court of Appeal, Third District, California.
Paul Jeffrey DAVIS, Plaintiff and Appellant,
v.
BOARD OF CHIROPRACTIC EXAMINERS,
Defendant and Respondent.
No. C059588.
(Super.Ct.No. 07CS00697).

April 12, 2010.

William J. Kopeny, Law Offices of William J. Kopeny, Irvine, CA, for Plaintiff and Appellant.

Office of the State Attorney General, San Diego, CA, for Defendant and Respondent.

RAYE, J.

*1 The Board of Chiropractic Examiners (Board) spent over $72,000 in its disciplinary proceedings against Dr. Paul Davis, a 20-year veteran chiropractor in both neurology and orthopedics, for his treatment and billing of a single patient who suffered two industrial accidents at two places of employment with different insurers. Neither the patient nor the insurers accused Dr. Davis of unprofessional conduct. Dr. Davis had never had a workers' compensation patient with claims against two insurers simultaneously, and he had never had a complaint filed against him by a patient or an insurer. The Board revoked his license but stayed the revocation, imposed a three-year term of probation,

and directed him to reimburse the Board for costs in the amount of $72,242.80.

Dr. Davis appeals the denial of his petition for a writ of administrative mandamus seeking to overturn the Board's findings. He frames his two appellate issues as questions of law, not fact. He contends that California Code of Regulations, title 16, section 318 (hereafter Board Regulation section 318) provides chiropractors with a 30-day safe harbor period during which they can correct billing errors and that he fell within the safe harbor by sending corrections to the insurers within 30 days of the conclusion of an in-house audit. Secondly, he asserts that "excessive treatment" is void for vagueness.

While the facts present an unusual context for a finding of professional misconduct, an appellate court is not at liberty to draw its own inferences from the facts. Rather, we are constrained to answer the only two legal questions presented. We conclude Board Regulation section 318 is not a safe harbor provision exonerating Dr. Davis for his negligent acts, and the prohibition for "excessive treatment" is not unconstitutionally vague. Thus, as a matter of law, we are compelled to affirm the denial of the writ of mandamus.

FACTS

The Patient

J.T. was a needy patient. In 1996 he hurt his wrist at work and sought treatment from Dr. Davis. That industrial injury is not at issue in this case.

Appendix 3

In November 1999 J.T., then in his early 20's, slipped and fell at HoneyBaked Ham during a busy shift just before Thanksgiving. He filed a workers' compensation claim that was handled by Highlands Insurance Company. On January 3, 2000, he sought treatment from Dr. Davis for the back injury he sustained in this slip and fall. J.T. asked so many questions that his initial interview extended over part of three days. He sought over 160 treatments for his back injury. Finally, approximately two years later he got too busy to continue his treatments when he returned to school.

In March 2000 he sustained his third industrial injury. While working at California State University at Fullerton, he tripped and fell down some stairs, spraining his ankle and exacerbating his back injury. He filed his third workers' compensation claim, which was handled by Superior National Insurance Company. Again, he sought over 100 treatments from Dr. Davis over the course of two years. He testified that the treatments alleviated his symptoms and he believed that Dr. Davis cared about him. Dr. Davis continued to patiently answer his voluminous questions during the entire time J.T. remained under his care.

Billing

***2** J.T. was the only patient during Dr. Davis's 20-year practice to be treated simultaneously for two industrial injuries at two different job sites covered by two different insurers. The complexity of the billing led to the unfortunate mistakes an inexperienced billing clerk made in Dr. Davis's office.

Dr. Davis's wife assumed responsibility for billing. She hired and trained staff. Hoping to provide a work

opportunity for a single mother with five children, she hired Norma Rosales from a welfare-to-work program. As far as Dr. Davis and his wife were aware, Ms. Rosales billed competently. They never received any complaints or notification from any insurer that she had erred on a bill. During the time that J.T. sought treatment for his back and ankle injuries, Dr. Davis's wife had a high-risk pregnancy and gave birth to a son with special medical needs. She therefore had reduced her workload and had delegated more of the billing during this time to Ms. Rosales.

On May 22, 2002, Dr. Davis was deposed in one of J.T.'s workers' compensation cases. Clifford Sweet, an attorney representing the insurer, accused him of billing irregularities. Although Dr. Davis held Mr. Sweet in very low regard, he instructed his wife to audit J .T.'s bills.

The audit was completed on July 30, 2002. It revealed there had been approximately 114 billing errors, some in favor of the respective insurer and some in favor of Dr. Davis. Dr. Davis's wife sent the corrected billings to Highlands Insurance on August 13, 2002, and to Superior National Insurance on August 21, 2002.

Dr. Davis and his wife both testified that he had very little to do with the billing practices in his chiropractic offices. He did not know most of the codes they were required to use. He relied on his staff to bill for his services.

Doctor Michael Stahl

Clifford Sweet retained Michael Stahl, D.C., in J.T.'s underlying workers' compensation case. Unlike Dr. Davis and his expert, Michael Martello, D.C., Dr. Stahl

is not a chiropractic orthopedist or a qualified medical examiner (QME). Yet Sweet represented to the Board that Dr. Stahl performed a QME evaluation. Dr. Stahl received a copy of Sweet's representation, but he did not correct it to reflect that he was not a QME. Only 15 percent of his practice involved patients seeking treatment for workers' compensation injuries, a substantial decline since the workers' compensation system was reformed in 2005.

Dr. Stahl testified that it is common in the industry to have billing staff. He accused Dr. Davis of double-billing and "up-coding" (charging for more services than were provided). Dr. Davis himself admitted his staff had made the mistakes but denied that he knew about them or intended to defraud the insurers.

Doctor Phillip Rake

Board expert Phillip Rake, D.C., saw no justification in Dr. Davis's records for the amount of treatment J.T. received. He opined the treatment was excessive because there was no medical necessity to support it and because over time it became "entirely palliative." Excessive treatment, according to Dr. Rake, violated the standard of practice, a standard that did not vary when chiropractors treated workers' compensation patients.

Doctor Paul Davis

*3 As a young boy, Dr. Davis yearned to become a chiropractor because his mother suffered acute back pain and he hoped to relieve his patients' pain. He became a diplomate in both chiropractic neurology and chiropractic orthopedics, a distinction earned by only

a few chiropractors nationwide. Until the filing of the instant accusation, the record reflects that Dr. Davis enjoyed an unblemished 20-year chiropractic practice, devoting long hours to treating his patients. Neither patients nor insurers registered any complaints.

Nevertheless, he admitted he delegated billing responsibilities to others. While he expected all of his staff to maintain high standards, he did not understand the nuances of billing, did not assure their accuracy, and did not realize that the bills to the two insurers in J.T.'s case were fraught with errors.

Dr. Davis explained the complexities of J.T.'s case, both in terms of treatment and of billing. J.T. was a high-maintenance patient requiring an unusual amount of time and patience. He came to his appointments with lists of questions. Dr. Davis attempted to address all of his concerns. Moreover, it was difficult to segregate the treatment he provided for one injury from the other, particularly because J.T. aggravated the back injury when he sprained his ankle. Finally, once J.T.'s condition became permanent and stationary and he was entitled to future medical services, Dr. Davis believed that J.T. was entitled to palliative treatment to minimize the discomfort of occasional flare-ups and to allow him to continue his daily activities. Dr. Davis does not dispute he treated J.T.'s back over 160 times and his ankle over 100 times.

Doctor Michael Martello

Michael Martello, D.C., at the time of the administrative hearing, had been practicing as a chiropractor for 23 years. During that time, he amassed an impressive array of certifications,

positions, and qualifications, including certification regarding disability evaluation in the State of California by the International Chiropractors Association of California; teaching continuing education programs in the State of California, primarily related to the treatment of industrial injuries; serving on testing panels for the Industrial Medical Council, and panels for the development of guidelines; membership in or on the American Board of Chiropractic Orthopedists, the California Society of Industrial Medicine and Surgery, and the board of trustees for the Western States Chiropractic College; serving as an examination commissioner for the American Board of Chiropractic Orthopedists and as a fellow of the International College of Chiropractors; recognition as chiropractic orthopedist of the year for the American Chiropractic College of Orthopedists; serving as chairman of the examining board for the American Chiropractic Academy of Neurology; diplomate of the American Board of Chiropractic Orthopedists; participation on the ethics committee for the California Chiropractic Association, the test development panel for QME's, and the task force on consumer complaints and unfair practices for the Department of Insurance; serving as a QME for the State of California; and, most significantly, serving as the vice-chairman of the California Board of Chiropractic Examiners.

*4 Dr. Martello reviewed J.T.'s entire file. As an expert on treatment, he testified that J.T. had sustained a multiple-level spinal injury. Simply put, this was not a simple back injury. Indeed, according to Dr. Martello, J.T. required extensive treatment to obtain permanent and stationary status. He would never fully recover from the back injury. "Because every patient is different, every injury is different, and every patient

responds to treatment differently," Dr. Martello opined that there was not a community standard for the number of treatments required for an injury like J.T.'s. Similarly, he could not say how many treatments it would take to treat the type of ankle sprain J.T. sustained because each patient's response to such an injury would be unique. In his view, there was no community standard for how many treatments an ankle injury would require.

Dr. Martello testified the Board had not codified any standard of care for the treatment of chiropractic patients in California. He distinguished the treatment guidelines available from the Industrial Medical Council from a standard of care, opining that the guidelines did not constitute a standard.

Despite the absence of a standard of care, Dr. Martello believed that spinal manipulation, electromusculostimulation, myofascia release, ultrasound, intersegmental traction, and massage were appropriate and necessary treatments for J.T.'s back injury. Dr. Martello stated, "It is a wonderful treatment plan. In fact, if I hurt my back that is the treatment plan I would want applied to me." Ultrasound, myofascia release, and massage were also appropriate and necessary treatments for J.T.'s ankle injury. They were "good for both an acute injury as well as a chronic injury." These treatments, according to Dr. Martello, should continue to be applied after the injuries become permanent and stationary to relieve pain, increase mobility, and reduce swelling. He testified that there could be a difference of opinion between chiropractors as to what treatment plans are appropriate but emphasized that the treating chiropractor is in the best position to evaluate the

patient, the healing process, and the response to the prescribed treatment.

Dr. Martello, like Dr. Rake, testified that chiropractic treatment must be justified by medical necessity. According to Dr. Martello, "[m]edical necessity is determined by a number of factors, including the patient's subjective complaints, most commonly pain or some other symptom, objective examination findings, a consideration of past treatment, and the patient's response to past care and whether there is a reasonable chance that the treatment will cure or relieve the effects of the injury." The failure to record subjective complaints did not negate the fact that the treatment provided was medically necessary.

Administrative Findings

Following a 10-day hearing, the administrative law judge (ALJ) made findings later adopted by the Board. As to billing, the ALJ found: "[I]n J.T.'s case, either the [health insurance claims forms (HCFA)] were not forwarded to respondent for his review, or they were forwarded to respondent and he failed to properly review the forms to ensure billing accuracy. In any event, it does not appear that respondent had the requisite knowledge to determine if the CPT codes [for] services/treatments rendered were properly reflected on the HCFA forms. Respondent testified that he is 'not familiar' with the 'coding,' and coding is so complex that it 'is a career in and of itself.' Respondent relied on 'others' to 'keep up with CPT and OMFS codes.' Respondent 'entrusted' his wife to ensure billing accuracy in 'that area.' Although respondent claimed that he reviewed the bills once the HCFA forms were completed, he 'does not know the codes.' Respondent's wife testified that respondent 'has

nothing to do with the billing.' Respondent's failure to ensure the accuracy of his billings constitutes negligent acts and, in the aggregate, gross negligence."

*5 The ALJ further reported on the number of errors in J.T.'s bills. "Numerous billing errors occurred in the present instance with respect to J.T. From January 2000 through October 2002, there were approximately 114 billing errors. The errors included double billing (both insurance companies billed for the same treatment), billing of incorrect CPT codes, billing the incorrect carrier, and billing for services not rendered on a particular date of service. [¶] ... Respondent was not aware of the billing errors due to his gross negligence and repeated negligence by not adequately supervising his billing procedures and billing staff, and by not reviewing the HCFA forms for accuracy prior to the forms being sent to carriers for payment."

As to J.T.'s treatment, the ALJ found: "The evidence and the reasonable inferences drawn from the evidence indicate that, in the present instance, after setting up the treatment plans for J.T. on the cover of J.T.'s chart, respondent delegated J.T.'s treatment and care to his (respondent's) chiropractic assistants. [Fn. omitted.] After the initial course of therapy, J.T. began scheduling appointments whenever he felt he needed them. J.T. would make his appointments, arrive at respondent's facility, be treated by one of respondent's employees/chiropractic assistants with massage, ultrasound, electrical stimulation, RICE, etc. These therapies made J.T. feel better, so he continued the treatments even though there was no medical necessity for the nature and number of the continued 'treatments.' Consequently, respondent was repeatedly negligent and acted in a grossly negligent manner in his treatment of J.T. by allowing J.T. to become

dependent, by providing treatments that were not medically necessary and by fostering chronicity."

The ALJ found no cause for discipline for any acts of moral turpitude, dishonesty, corruption, fraud, or misrepresentation, or for knowingly presenting false insurance claims. He did, however, conclude there was cause for discipline for his commission of acts of gross negligence in billing J.T.'s insurers and for providing J.T. excessive treatment, both of which constitute unprofessional conduct.

Administrative Mandamus

Apparently frustrated by the anemic record provided by Dr. Davis, particularly the number of missing exhibits, the trial court concluded that he failed to meet his burden of establishing that the findings are not supported by the weight of the evidence. He does not challenge this ruling or the court's evaluative analysis of the weight of the expert evidence.

Dr. Davis instead challenges two legal issues. The trial court found that the inclusion in California Code of Regulations, title 16, section 317, subsection (d) (hereafter Board Regulation section 317) of " '[t]he administration of treatment or the use of diagnostic procedures which are clearly excessive as determined by the customary practice and standards of the local community of licensees' " as unprofessional conduct is "not unconstitutionally vague, and that written, formally adopted guidelines are not necessary."

***6** As to the second issue, the court also lamented Dr. Davis's failure to provide a copy of the deposition wherein it was alleged that he was given notification of the J.T. billing errors. The court stated it would not

find an abuse of the Board's discretion on the record provided. The court did conclude, however, that it was not persuaded the "30-day period began on July 30, 2002, when his office administrator, his wife, concluded the review of billings which he had requested her to perform." Even if Dr. Davis had corrected the billings within 30 days, the court found "the evidence supports the finding that he was negligent in regard to billings. Petitioner is responsible for the actions of his staff, which he did not properly supervise. [Board Regulation] Section 318 does not provide a 'safe haven' against claims of negligence."

Dr. Davis appeals the denial of his petition for a writ of administrative mandamus.

DISCUSSION

I

Billing Errors

Board Regulation section 318, subdivision (b) provides: "Accountable Billings. Each licensed chiropractor is required to ensure accurate billing of his or her chiropractic services whether or not such chiropractor is an employee of any business entity, whether corporate or individual, and whether or not billing for such services is accomplished by an individual or business entity other than the licensee. In the event an error occurs which results in an over billing, the licensee must promptly make reimbursement of the over billing whether or not the licensee is in any way compensated for such reimbursement by his employer, agent or any other individual or business entity responsible for such error. Failure by the licensee, within 30 days after discovery or notification of an

error which resulted in an over billing, to make full reimbursement constitutes unprofessional conduct."

Dr. Davis contends that the final sentence of Board Regulation section 318, subdivision (b) provides a safe harbor for chiropractors; that is, a chiropractor remains immune to charges of professional misconduct provided he or she corrects the errors and makes full reimbursement during the 30-day grace period. He further argues that the Board and the trial court erred as a matter of law by construing "discovery or notification" to mean mere "notice." In Dr. Davis's view, he was wrongfully denied the benefit of section 318's safe harbor based on the erroneous finding that he was notified of the errors at the deposition on May 22, 2002, rather than at the completion of his in-house audit on July 30, 2002. We need not construe the meaning of "discovery or notification" because we conclude section 318, subdivision (b) does not provide a 30-day safe harbor for negligence.

Other statutes and regulations provide a general framework relevant to our analysis. Pursuant to section 10, subdivision (b) of the Chiropractic Act (3A, pt. 1, West's Ann. Bus. & Prof.Code (2003 ed.) pp. 442-443), the Board may take disciplinary action based on any violation of the rules and regulations adopted by the Board in accordance with the Chiropractic Act or for any cause specified in the act. Board regulation section 317, subdivisions (a) and (b) state that unprofessional conduct includes, but is not limited to, gross negligence and repeated negligent acts.

*7 We agree with the Attorney General that under this framework the first sentence of Board Regulation section 318, subdivision (b) is dispositive. The first sentence imposes a duty on chiropractors to "ensure

accurate billing of his or her chiropractic services." The Board found Dr. Davis guilty of gross negligence in billing. Thus, his billing constituted unprofessional conduct under Board Regulation section 317, and the Board was justified in taking disciplinary action based on Dr. Davis's violation of the rules and regulations set forth in section 318, subdivision (b). Whether the insurers brought the billing errors to his attention is irrelevant to his duty to prevent them from occurring in the first place.

Yet Dr. Davis insists the final sentence provides a 30-day safe harbor during which he could evade responsibility for his negligence by correcting the errors and making full reimbursement. He cites no authority to support such an escape valve. We agree with the trial court that "[s]ection 318 does not provide a 'safe haven' against claims of negligence."

First, we turn to the language of the regulation, written as it is in the negative rather than the positive. Certainly, the regulation does not state that chiropractors have 30 days to correct errors; rather, it states the reverse-that the failure to correct errors within 30 days constitutes unprofessional conduct. Thus, if the Board has evidence the chiropractor either discovered or was notified of an error and did nothing to correct it within 30 days, there is cause for disciplinary action for unprofessional conduct. In short, the last sentence speaks to a failure to act once an error is discovered; it does not exonerate a chiropractor for gross negligence or repeated acts of negligence.

Second, we reject the notion that the Board intended to give chiropractors a 30-day free pass for negligence when the express intent of the section is to impose a

stringent duty on them to ensure accurate billing. Board Regulation section 318, subdivision (b) imposes such a duty on chiropractors "whether or not billing for such services is accomplished by an individual or business entity other than the licensee." Thus, the scope of responsibility is expansive. A chiropractor's professional obligation to ensure accurate billing extends to any form of business and any form of billing. We will not presume that the Board intended to create such a gaping loophole for negligence at the same time it found a need to impose a kind of strict liability on chiropractors to make sure all billing for chiropractic services is accurate.

In reply, Dr. Davis contends he was not disciplined for errors in his billings, but because he was on notice of those errors. Not so. The Board found cause for discipline because of Dr. Davis's "failure to ensure accurate billing *and* his failure to correct the erroneous billing within 30 days after discovery of the errors." The Board also found Dr. Davis "committed acts of gross negligence, in violation of Board Regulation section 317, subdivision (a), by submitting numerous erroneous bills to Highland and Superior...." Contrary to his position on appeal, Dr. Davis was disciplined for errors in his billings.

*8 Moreover, Dr. Davis mischaracterizes the Attorney General's argument. He contends the Attorney General claims that any failure to ensure accurate billing, even if the chiropractor is unaware of the errors, constitutes "negligence." Nor did the Board find that any failure constituted negligence; it found that Dr. Davis's failure to supervise his billing staff and to understand the billing codes constituted gross negligence. Based on the 114 errors and Dr. Davis's own admission that he had nothing to do with the

billing, there was ample evidence to support the finding of negligence, whether or not he had notice of the errors.

II

Excessive Treatment

Dr. Davis contends that Board Regulation section 317, subdivision (d) and section 725 of the Business and Professions Code are unconstitutionally vague and therefore void as applied to his case. Eschewing the parties' squabble over who waived the issue at what level, we review de novo as a question of law the constitutional challenge, except as to those facts upon which the application of the regulation and statute depend. We must defer to any factual findings supported by substantial evidence regarding a standard of practice for chiropractors.

Board Regulation section 317 provides, in pertinent part: "Unprofessional conduct includes, but is not limited to, the following: [¶] ... [¶] (d) The administration of treatment or the use of diagnostic procedures which are clearly excessive as determined by the customary practice and standards of the local community of licensees." Business and Professions Code section 725 states that "repeated acts" of clearly excessive treatment, as determined by the "standard of the community of licensees," constitutes "unprofessional conduct" for which a licensee may be disciplined.

Dr. Davis maintains that "excessive treatment" is so vague that he has to guess at its meaning and people of common intelligence differ as to its application. As a result, there is the dangerous and real possibility of

arbitrary and discriminatory enforcement of the regulation and statute. (*People v. Duz-Mor Diagnostic Laboratory, Inc.* (1998) 68 Cal.App.4th 654, 670, 80 Cal.Rptr.2d 419.) He urges us to find such an elusive concept as "excessive treatment" unconstitutional and, therefore, void.

It is true that "[r]ules and 'statutes must be sufficiently clear as to give a fair warning of the conduct prohibited....' [Citation.] This prohibition against vagueness has been held to extend to administrative regulations affecting conditions of governmental employment. [Citation]." (*Arellanes v. Civil Service Com.* (1995) 41 Cal.App.4th 1208, 1216, 49 Cal.Rptr.2d 73.)

We do not assess the vagueness challenge to the statute and regulation in the abstract but in light of the facts of the case before us. (*Cranston v. City of Richmond* (1985) 40 Cal.3d 755, 764, 221 Cal.Rptr. 779, 710 P.2d 845.) Dr. Davis treated J.T. over 100 times for his sprained ankle and over 160 times for his sore back. He contends there is no standard number of treatments or standardized protocol against which his care of J.T. can be measured. But "where the language of a statute fails to provide an objective standard by which conduct can be judged, the required specificity may nonetheless be provided by the common knowledge and understanding of members of the particular vocation or profession to which the statute applies." (*Id.* at p. 765, 221 Cal.Rptr. 779, 710 P.2d 845.)

***9** Indeed, Board Regulation section 317, subdivision (d) codifies that very principle. It states that unprofessional conduct includes treatments "which are clearly excessive as determined by the customary

practice and standards of the local community of licensees ." Dr. Davis insists the definition is unconstitutionally vague because the Board's expert testified the number of treatments he provided J.T. was excessive and his expert testified they were not. He concludes there is no standard when even the experts disagree. Not so. If expert witnesses had to agree in order to establish customary practice or standards, there would be few, if any, standards of practice since it is easy to retain an expert witness to express an errant view.

Here the court found the testimony of Dr. Phillip Rake to be more persuasive than the testimony of Dr. Michael Martello. Dr. Rake testified treatment is excessive, according to community standards, when it is not medically necessary. It is not sufficient for the initial treatment plan to be medically necessary; over time, a chiropractor must continue to assess a patient at each visit to determine whether continued treatment is necessary. According to Dr. Rake, if a patient does not improve, then the course of treatment should be modified or discontinued. Based on Dr. Rake's testimony, the trial court concluded, "Patient JT's subjective belief regarding the benefits of the treatment provided do not override Dr. Rake's opinion regarding community standards and the lack of documented medical necessity in JT's medical file." This is a factual finding we are not at liberty to upset since there is substantial evidence to support it.

Dr. Davis attempts to equate "excessive treatment" with "grossly improbable statements," a vague criteria rejected by the Supreme Court in 1906. (*Hewitt v. State Board of Medical Examiners* (1906) 148 Cal. 590, 84 P. 39 (*Hewitt*).) In an era when advertising was still deemed unprofessional, the Legislature prohibited

doctors from making "grossly improbable statements," but as the Supreme Court pointed out, it did not pretend to define what constitutes "grossly improbable statements." The Supreme Court explained, "[N]or is there any definite rule declared whereby after such advertisement is had the board of medical examiners shall be controlled in determining its probability or improbability. The physician is not advised what statements he may make which will not be deemed 'grossly improbable' by the board. No rule is provided whereby he can tell whether the publication he makes will bring him within the ban of the provision or not. The advertisement in connection with his medical business may be made in entirely good faith; the statement may be of such a character that it involves no moral delinquency on the part of the physician, nor in any degree tends to deceive or injure the public. These matters, however, have no controlling effect." (*Id.* at pp. 593-594, 84 P. 39.)

***10** Unlike in *Hewitt,* neither the challenged statute nor regulation confers on the Board unfettered discretion to make an ex post facto determination of prohibited conduct. Rather, the local community of chiropractors provides the standard. Our opinion in *Holt v. Department of Food & Agriculture* (1985) 171 Cal.App.3d 427, 218 Cal.Rptr. 1 (*Holt*) provides a much more apt analogy.

In rejecting a pest control operator's vagueness challenge, we concluded, "[T]he statutes and regulations provide sufficiently clear standards to give fair notice of the proscribed conduct." (*Holt, supra,* 171 Cal.App.3d at p. 432, 218 Cal.Rptr. 1.) In an earlier case we had rejected the same challenge to the phrases " 'faulty, careless or negligent manner,' 'circumstances where injury is likely to result to plants ... through

drift,' and 'reasonable precautions ... to confine the material applied substantially' to the intended area." (*Ibid.*, quoting *Wingfield v. Fielder* (1972) 29 Cal.App.3d 209, 216-217, 105 Cal.Rptr. 619.) Our rejection of the challenge is equally applicable to the case now before us. We wrote: " 'The operator is given sufficiently definite notice as to the proscribed conduct when measured by common understanding and practice and in the light of the potential for harm involved in the use of pesticides by aerial application.' " (*Holt*, at p. 432, 218 Cal.Rptr. 1.) The standards were " 'not at all vague but are sufficiently definite and certain to anyone associated with crop dusting or spraying by air.' " (*Ibid.*)

Similarly, while there is no precise number of treatments prescribed for a particular injury because of, as Dr. Martello explained, the difference in patients and how they respond to treatment, "excessive treatment" is sufficiently definite and certain to the local community of chiropractors. Because Board Regulation section 317, subdivision (d) and section 725 of the Business and Professions Code both define excessive treatment by reference to the standards adhered to by the local community of chiropractors, we reject Dr. Davis's contention that "excessive treatment" is too vague to pass constitutional muster. As applied to the facts before us, Dr. Davis's ostensible legal challenge is nothing but a disguised factual challenge to the sufficiency of the evidence to support the finding that under the standard accepted by local chiropractors the treatment he provided J.T. was excessive.

Dr. Davis raises a slightly different issue he also characterizes as a legal question. He asserts that the superior court agreed with the Board's legal conclusion

that treatments are excessive if given to ameliorate pain but with no curative effect. We disagree with his reading of the record. Neither the trial court nor the Board found, in derogation of former section 4600 of the Labor Code, which provides that an injured worker is entitled to treatments that "cure or relieve" the symptoms of an industrial injury, as a matter of law that any treatment to relieve pain alone was excessive. Rather the Board, sustaining the factual findings of the ALJ, found: "After the initial course of therapy, J.T. began scheduling appointments whenever he felt he needed them. J.T. would make his appointments, arrive at respondent's facility, be treated by one of respondent's employees/chiropractic assistants with massage, ultrasound, electrical stimulation, RICE, etc. These therapies made J.T. feel better, so he continued the treatments even though there was no medical necessity for the nature and number of the continued 'treatments.' Consequently, respondent was repeatedly negligent and acted in a grossly negligent manner in his treatment of J.T. by allowing J.T. to become dependent, by providing treatments that were not medically necessary and by fostering chronicity."

*11 Dr. Davis and Dr. Martello opined that an industrially injured worker designated "permanent and stationary" was entitled to future medical treatments at the sole discretion of the patient. It is very different to argue that a patient is entitled to treatment to ameliorate pain than it is to contend a patient is entitled to unfettered access to massage and ancillary services. As a matter of law, an injured worker may be entitled to future medical treatment to stabilize and maintain a permanent injury, but as a matter of fact, the patient may not be entitled to unlimited treatment to feel better. Because in this case the administrative tribunal as fact finder found that

Dr. Davis negligently fostered J.T.'s dependency on treatments and negligently authorized his staff to provide feel-good treatments on demand, we reject Dr. Davis's argument that he provided "excessive treatment" as a matter of law once J.T.'s condition became permanent and the treatments targeted pain relief.

In his reply brief, Dr. Davis represents that the Board expert "testified that it is not medically necessary for a chiropractor to treat pain, unless he can also cure the patient." He provides no citation to the record. Again, we read his testimony differently. Dr. Rake explained at some length how Dr. Davis failed to document or record J.T.'s subjective complaints. He testified: "Again, I did see rexams [*sic*]. Again, I have no problem with rexams [*sic*]. The problem I have is there was no information regarding the subjective complaints on the rexams [*sic*], in the SOAP notes or on the flow sheets that I could find to correlate the rexams [*sic*]. For example, out of-I think there were 24 or 25 total examinations for these two work comp cases-conditions. Out of the 24 or 25 rexams [*sic*], I only found two or three of the exams where the subjective finds for the patient's complaints were actually documented. So I had about 22 rexams [*sic*] being performed for what? What was the purpose? What were the patient's complaints? How were they getting better? How were they getting worse? Were they having any radiating pain? Was their work aggravating their conditions? Was their care beneficial at that point? Was there a pain scale performed? Were outcome assessment questionnaires utilized to determine scientific basis for ongoing care? The key nowadays for ongoing care would be the assessment questionnaire, which has more validity than the

doctor's physical exam finding to support ongoing care."
Thus, Dr. Rake concluded the treatment was excessive, not because a chiropractor can never provide treatment for pain relief, but because Dr. Davis failed to record J.T.'s subjective complaints. The failure to document the need for pain relief leaves open the question whether Dr. Davis ever inquired or not. We reject his contention, however, that the finding of excessive treatment was based on the wholesale legal proposition that chiropractors cannot treat injured workers to ameliorate their pain.

*12 Finally, Dr. Davis complains the regulation is vague because it does not define a "local community," and it was unconstitutionally applied because the experts relied on chiropractic standards throughout the state. He made no attempt to prove the standard for excessive treatment varied within the state. We believe that people of common intelligence can discern the meaning of local community, and in the absence of evidence that the standard applicable to this case varied throughout California, we conclude the regulation survives constitutional scrutiny.

III

Cost Reimbursement

Dr. Davis does not challenge the penalty on appeal. He mentions the order compelling him to reimburse the Board $72,242.80 in costs at the end of his opening brief, without citation or argument, and makes no mention of these costs in reply. As a result, any issue as to whether these costs were excessive is not before us. Indeed, this chiropractor has paid an extremely steep price for his transgressions involving a single,

difficult patient who presented unique billing challenges for the welfare-to-work clerk responsible for separating charges from two industrial accidents to two different parts of the body and deciphering a complex billing code particular to the workers' compensation system. Although we may empathize with Dr. Davis, our limited role is to answer the questions of law presented, and for the reasons discussed at length above, we must answer those questions adversely to him.

DISPOSITION

The judgment is affirmed.

We concur: NICHOLSON, Acting P.J., and ROBIE, J.

Cal.App. 3 Dist.,2010.
Davis v. Board of Chiropractic Examiners
Not Reported in Cal.Rptr.3d, 2010 WL 1434322 (Cal.App. 3 Dist.), 75 Cal. Comp. Cases 465

Appendix 25

SUPREME COURT
FILED
July 14, 2010
Frederick K. Orlrich, Clerk

Deputy

Court of Appeal, Third Appellate Dist. - No. C059588

S182935

IN THE SUPREME COURT OF CALIFORNIA

En Banc

PAUL JEFFREY DAVIS, Petitioner and Appellant,

v.

BOARD OF CHIROPRACTIC EXAMINERS, Defendant and Respondent.

The petition for review is denied.
The requests for an order directing publication of the opinion are denied.

GEORGE
Chief Justice

Appendix 26

United States Constitution
Amendment XIV
Section 1.

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

California Administrative Code
Title 16, Section 317
Subsections (a) - (d)

The board shall take action against any holder of a license who is guilty of unprofessional conduct which has been brought to its attention, or whose license has been procured by fraud or misrepresentation or issued by mistake.

Unprofessional conduct includes, but is not limited to, the following:

(a) Gross negligence; (b) Repeated negligent acts; (c) Incompetence; (d) The administration of treatment or the use of diagnostic procedures which are clearly excessive as determined by the customary practice and standards of the local community of licensees;

Appendix 27

California Administrative Code
Title 16, Section 318
Subsection (b)

Accountable Billings. Each licensed chiropractor is required to ensure accurate billing of his or her chiropractic services whether or not such chiropractor is an employee of any business entity, whether corporate or individual, and whether or not billing for such services is accomplished by an individual or business entity other than the licensee. In the event an error occurs which results in an over billing, the licensee must promptly make reimbursement of the over billing whether or not the licensee is in any way compensated for such reimbursement by his employer, agent or any other individual or business entity responsible for such error. Failure by the licensee, within 30 days after discovery or notification of an error which resulted in an over billing, to make full reimbursement constitutes unprofessional conduct.

California Labor Code
Section 4600, First Paragraph

(Former - Effective 1998-2004)

Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve from the effects of the injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment. After 30 days from

the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. However, if an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury. If an employee requests a change of physician pursuant to Section 4601, the request may be made at any time after the injury, and the alternative physician, chiropractor, or acupuncturist shall be provided within five days of the request as required by Section 4601. For the purpose of this section, "personal physician" means the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history. Underlining supplied.